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RACP Submission to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22

July 2021

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 18,863 physicians and 8,830 trainee physicians, across Australia and New Zealand. The RACP represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, infectious diseases medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) regarding its Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021-22 ('Consultation Paper'). We appreciate the consideration the IHPA has given to past College feedback, such as on rebalancing the fixed cost to variable cost weighting to create a greater buffer in the form of a larger fixed cost component for hospital funding.

The RACP is a key stakeholder in IHPA's development of the Pricing Framework for Australian Public Hospital Services, having a membership of consultant physicians from varied specialties who provide services not only in the public hospital system but in other sectors of our health care system. We are pleased to provide our perspective on key consultation questions raised in the Framework.

Two underlying messages from the RACP are that:

1) The ongoing impact of COVID-19 highlights the importance of a coordinated, sector-wide approach to health service planning and management, in which payment and funding systems are aligned to meet safe, quality patient care outcomes and the efficient reimbursement of resources used and commissioned in the most appropriate site (encompassing the virtual).

2) As both the Australian Government and jurisdiction governments transition to a more integrated and less linear health care system, as supported by the Addendum to the National Health Reform Agreement 2020–25 (the Addendum), the College encourages the re-thinking of definitions of activity such that a unit or "episode of care" is defined less by hospital site location and more by the inclusive and comprehensive treatment of a presenting condition(s).

The College feedback relates to these areas:

1. Impact of COVID-19
2. Classifications used to describe and price Public Hospital services
3. Setting the National Efficient Price (NEP)
4. Pricing for funding and quality
5. Future funding models.

1. Impact of COVID-19

The Consultation Paper seeks feedback on how IHPA proposes to assess the impact of COVID-19 on the cost and activity data used to determine the National Efficient Price and the potential resultant changes to the national pricing model. We note that the NEP Determination 2022–23 (NEP22) will be based on 2019–2020 costed activity data, which includes three months of costed activity data in 2020 impacted by the COVID-19 pandemic response. The IHPA states that it has considered recent changes to how patients access services, such as non-admitted care delivered via telehealth being priced under the non-admitted care pricing model and hospital-in-the-home services being priced under the admitted acute care pricing model.

For the immediate future, we expect that many of the factors impacting cost and activity because of COVID-19 will continue for varying periods and across different states and regions at different and unpredictable times. This will result in fluctuating variable costs, that is periods of reduced on-site patient (patient facing) activity followed by surges stemming from delayed care or exacerbations and rescheduled services. Without reform to the way in which health services are organised, in ways that make services more responsive to changing circumstances and more flexibly delivered, it may also mean stop-gap services need to be provided until such time as planned hospital services can resume.

On data sources, the use of recent activity data is a useful approach. For elective surgery, such as diagnostic endoscopies, recent activity can be sourced from waitlists and current records rather than historical data. The IHPA will be aware that jurisdictional decisions will influence the funding assigned towards activities, which must consider volume.

Hospital services must be well-resourced, particularly in periods of pandemic outbreak risks, to reduce the likelihood of avoidable resource and cost pressures such as re-admissions, the development of complications and increased length of stay.

COVID-19 protocols can be expected to continue to impact per patient unit costs as described last year:

- Increased personal protective equipment (PPE) use.
- Increased use of isolation facilities in hospitals for patients with or suspected of having COVID-19, mitigating the risk of Emergency Department (ED) overcrowding.
- The repurposing of existing hospital space for the creation of pragmatic isolation accommodation in general wards.
- Increased utilisation of both PCR and rapid antigen COVID-19 tests.
- Increased use of other diagnostics to exclude COVID-19 complications or make positive alternative diagnoses.

Experience shows that mask wearing also adds demands in relation to delivering services to certain patients, for example in assessing and communicating with patients who are deaf, confused patients or otherwise challenged patients when a clinician’s face is not visible.

COVID-19 can also impact discharge processes and hospital length of stay in situations where patients cannot be safely discharged (for example to residential aged care facilities). Especially in the periods of lockdown, this has led to an increased length of stay in subacute settings, including rehabilitation units. The experience of our members is that while there was an initial reduction in ED and inpatient numbers, subsequently there has been a significant increase. The reasons are:

- COVID-19 related.
- GPs are seeing fewer patients face to face.
- Patients with respiratory illnesses are coming to the hospitals.

- Due to GP non-attendance in residential aged care facilities (RACFs) there are additional delays in hospital discharge to RACFs (this may change with recent announcements of practice incentives to GPs).
- Increased length of stay to allow for COVID-19 clearance before going to other speciality wards.

The impact within the hospital and its costs are described as:

- Protective responsive alterations to the medical model of care to mitigate risk to medical teams from exposure from a single COVID-19 contact event to multiple staff. This has produced additional stress on rostering to cover all the different sites.
- Increased complexity of multiple teams being consulted and transfers of care.
- An increase in the workload of Local Health Districts/Networks (LHNs) where they have had to expand outreach services to provide COVID-19 preparedness and general geriatric medical services using telehealth because of the focus on residential aged care facilities.
- An unmanageable surge in adolescent mental health and eating disorder presentations coinciding with community lockdowns. There has been an increase in complex adolescent behaviours, aggression and violence which consume resources in excess of current funding models. This has the deleterious effect of compromising care. We further suggest that loadings should be applied for complexities and comorbidities associated with this age group.
- Some duplication of facilities with equipment may be required to be prepared to continue services in the event of outbreaks.
- Anticipated demand for acute care relating to mental health, noting also that clinicians may be in short supply at different times due to burn out.
- Economic circumstances leading people to discontinue their private health insurance cover which can be expected to lead to increased demand on public hospital activity.
- Overall increase in the complexity of service delivery. For clinic attendances, it is proposed there is a need to increase the national weighted activity unit (NWAU) to recognise that services are necessarily more complex and time consuming.
- Impact on rehabilitation services following presentations by patients after acute events such as stroke, falls or late cancer diagnoses with significant levels of functional impairment and new disabilities. There are an increasing number of patients with chronic health conditions who did not get their usual health care, patients who did not get cancer screens and older patients who have become more isolated and deconditioned.
- Reported experience that during 2020 many subacute rehabilitation beds were closed and converted to become potential COVID-19 wards. Some experience states these beds have never been reopened which has had the effect of exacerbating bed access issues across the entire health system, compounded by the increasing presentations to hospital of people with illnesses associated with new disabilities. The return of demand for rehabilitation beds combined with reduced access to these beds might result in incorrect inpatient activity data and flow-on effects in funding allocations. The lack of access to rehabilitation beds/services not only impacts health services all the way back to ED but results in poorer long-term outcomes for rehabilitation patients.
- Hospitals trialling non-admitted options for rehabilitation. While these trials may or may not be continued in the longer term, they will nevertheless impact on the level of recorded inpatient activity for these units. As such, these programmes should be correctly recorded and reflected in the IHPA's pricing framework. Examples of applicable hospital rehabilitation services include day rehabilitation programmes and home-based rehabilitation.

We wish to highlight how COVID-19 has exposed preventable vulnerabilities and gaps in the implementation of work, health and safety provisions for health care workers, notably in public hospitals. This is where the engagement in hospitals of occupational and environmental physicians should be supported to reduce avoidable incidents and costs.

Evidence of the benefits of the investment in factoring in occupational and environmental medicine in hospitals to employees is referenced by the example of the Mater Hospital group.[1] This strategy led to an improvement in the return-to-work rates of Mater employees who made worker compensation related claims so that they were higher than other hospital groups in Queensland. For example, in the first year that occupational and environmental medicine oversight was engaged (2013-14), approximately 80% of injured Mater hospital employees were able to immediately return to work following their assessment and treatment compared to the industry average of around 30%.[2] Subsequent data has continued to support the significantly better outcomes for the Mater group (more than 75% immediate return to work) compared to the industry average (under 50%). There are two economic implications here:

- The potential for reductions in worker compensation premiums for hospital groups
- The value of factoring in and embedding in the healthcare systems key specialists who have relevant expertise and who to date have not been optimally incorporated into the general models of care for hospitals.

COVID-19 and pre-existing resource pressures on hospital services

COVID-19 has affected hospital service patient flow by impacting the number of beds and staff available to patients from emergency departments. Hospital waitlists and activity have experienced a compounded impact not only from COVID-19, but also through these pre-existing resource pressures:

- The increased proportions of patients with chronic conditions.
- A high proportion of older people in the Australian population. People aged 65 years or more constituted around 40 per cent of all public hospital separations in 2017-18 and once admitted, are in hospital for 33 per cent longer than all other age cohorts.[3]
- Increasing hospital activity. The Bureau of Health Information data shows that over five years, ED attendances increased by 12.9% from 672,675 in January to March 2016 to 759,157 in January to March 2021 (2.3% were identified as patients likely to be in for a COVID-19-19 test). In 2021, the number of hospital bed days for acute episodes was the highest of any January to March quarter in the five-year period.[4]
- Bed availability; in 2017-18, the ratio of public hospital beds for every 1,000 people aged 65 years and older declined for the 26th consecutive year to 16.0.[5]

These factors have placed and will continue to place mounting pressure on the existing supply of bed and staff numbers.

We also emphasise the importance of factoring in the costs needed to better integrate services digitally across organisations, not least to assist in safe patient transfers and discharge to community sites of care. This will become increasingly essential to ensure a more coordinated health system and support the use and expansion of virtual hospitals, telehealth services, home care and hospital-in-the-home, and the development of virtual emergency departments.

In the coming years it may be difficult to attribute variance in activity and costs strictly to COVID-19 as new ways of delivering health care services become embedded or are trialled. There is the potential for new trends to emerge which may be temporary. Nonetheless, the degree of variance from 2019-2020 data is likely to continue to be a reference point.

[1] Written feedback provided by AFOEM member. More details are available on request.
[2] Written feedback provided by AFOEM member. More details are available on request.
[3] AIHW Admitted patient care 2017–18: Australian hospital statistics
[4] Bureau of Health Information. Healthcare Quarterly, Trend report, Emergency department, ambulance, admitted patients and elective surgery, January to March 2021. Sydney (NSW); BHI; 2021
[5] Australian Medical Association Public Hospital Report Card 2020

2. Classifications used to describe and price public hospital services

A new non-admitted care classification

The College considers the development of a new non-admitted care classification to better describe patient characteristics and care complexity to be important at the time when more innovative and cost-efficient models of health care service delivery are being explored. We are pleased to see this work progressing after last year's pause.

If non-admitted services such as ambulatory rehabilitation or hospital-in-the-home are regarded as an equivalent service to admitted services, it stimulates investment in these approaches. Hospital-in-the-home and ambulatory care models for rural areas would help to offset demand for acute hospitals in these areas. Exploration of a pricing model should involve hospital-in-the-home models that have been shown to reduce acute and subacute bed utilisation for conditions such as cellulitis, pneumonia and COPD, and sub-acute ambulatory models to shift certain activity away from an admitted environment.

The non-admitted care classification categorises a non-admitted clinic as a single class, where often clinics perform a range of health services wider than those of a particular class. The predominant activity of a clinic may be a more realistic means of classification.

Difficulties have been also raised in capturing and assigning the range of activities for some outpatient service clinics. One example might be for Ambulatory Care Services that may include a hospital-in-the-home program, daily specialist consultation services, an ambulatory care day ward and a falls prevention clinic. There appear to be differences between hospitals in the way ambulatory care patients and services are classified.

The IHPA's goal of supporting state and territory readiness for recommencing the non-admitted care costing study might best be achieved by collaborating with states to leverage recent data sources such as Electronic Medical Records for costing purposes. Any outsourced activity should also be captured in data collection.

3. Setting the NEP

Price harmonisation

The IHPA could consider applying the principle of price harmonisation to some services provided in ambulatory care to better incentivise the treatment of certain patients in ambulatory settings. For example, treatment of cellulitis, deep vein thrombosis or pneumonia and ambulatory rehabilitation services can be delivered in ambulatory settings, but such patients are sometimes admitted.

Adjustments to NEP

- ***Patient transport in rural areas***

We understand that in developing NEP22, IHPA is investigating the need to review or assess existing or new adjustments such as reinvestigating an adjustment for patient transport in rural areas.

We support the IHPA's proposal for an adjustment in the NEP to reflect patient transport in rural areas, including medical transfers and other inter-service transports in rural areas. Rural patient transport is often unavailable for the transport of patients to specialist public hospital physicians for definitive care; this is exacerbated with regards to COVID-19 as demand for such transportation increases.

We recommend that the adjustment for patient transport should incorporate the cost of support for escorts to accompany patients from their rural homes to specialist care. Rural patients who face hospitalisation alone are disadvantaged in every aspect of hospitalisation. The provision of patient escorts would improve comfort, communication, and adherence to care including reducing discharge against medical advice, and help to address some of the psychosocial aspects of health care which is also important to outcomes.

While there are State and Territory based Patient Assisted Travel Schemes, evidence suggests these have different eligibility criteria and varying and insufficient travel and accommodation benefits.[6] It is essential that the above discussed costs are captured when it comes to funding of patient transport services to enable rural and remote patients to access timely and clinically appropriate specialist care, whether ambulatory or inpatient.

Introducing the proposed adjustment will also enhance transparency of such funding, ensuring that funding allocated for patient transport is used for that purpose as the alternative is that unused funds for patient transport are returned to individual Hospital and Health Services (HHSs) general revenue, which may disincentivise HHSs from supporting patient applications for the subsidy.

We also suggest that travel support for non-admitted patients should be amended to include allied health and dental care. Currently Patient Travel Assistance (PATS) only covers medical referrals. This means there may be unnecessary referrals for services such as radiology to enable disadvantaged Australians to access dental care. It is further suggested that the lack of access to PATS for physiotherapy and psychology services contributes to an excess of opiate use in rural areas.

- ***Review of the Indigenous adjustment***

A significant number of Indigenous patients involve complex presentations; given the imperative to ensure access to quality health services by Indigenous people, we suggest that a financial loading is a good way to translate this priority into action and is consistent with the IHPA principle of timely quality care.

In addition, the IHPA could consider applying a weighting to activity provided by ACCHOs and by Aboriginal Health Practitioners.

Ambulatory/Outpatient/Consultative services for Indigenous people

- Public hospitals provide the bulk of ambulatory specialist services for Indigenous people. The activity-based funding models for ambulatory services should reflect the complexity, multidisciplinary needs and time requirements to provide quality care and incentivise Indigenous persons to be seen by specialists. This would help to rebalance the current situation in which Indigenous people can experience reduced access to care which contributes to poor health outcomes.
- Complexity is a key factor for consultative services and can more than double the length of consultation and require extensive follow up. The IHPA could consider tiers based on complexity relating to the number of physical problems, psychosocial complexity (where psychological morbidity or social disruption contribute to an increased cost of service delivery) and a time-based component relating to resources used.

[6] Bachman et al. Patient Assisted Travel Schemes: are they actually assisting rural Australians? http://www.ruralhealth.org.au/14nrhc/sites/default/files/PosterPaper_Irwin%2C%20Rebecca.pdf, last accessed October 12, 2020.

Admitted services for Indigenous people

- If an admitted patient identifies as Indigenous, they should be offered the assistance of an Aboriginal Liaison Officer (or equivalent); this, being relatively expensive, could be incentivised with a small loading. There are two components contributing to these costs:
    - the infrastructure Aboriginal Liaison Officers (or equivalent) need to do their work (e.g., transport; accommodation, sometimes temporary accommodation for family members who travel to assist with care)
    - the infrastructure needed to support Aboriginal Liaison Officers (or equivalent) and Aboriginal Health Units within hospitals.

- ***Supporting increased costs for genetic services or socioeconomic status***

The key issue regarding this matter is incomplete data in national and state data collections.

- The costs of sendaway genetic testing have been underestimated. Most genetic tests are sent away to other hospitals, interstate or overseas laboratories. The costs of these tests are not uniformly collected or available and will be missed or underestimated using standard datasets. This data is available in each jurisdiction and could be extracted should IHPA work directly with genetic services to capture accurate data.
- The cost of genetic services is underestimated due to the complexity and rareness of the conditions that in most cases require review of the literature, multisystem impact on patients, the administrative burden of genetic testing, consent, and result interpretation. The family implications of these conditions have far-reaching impact but are not documented using standard outpatient activity reporting. The true time spent on each family accessing genetics services has been estimated in previous publications based on Australian Genetics workforce surveys as 6.25 hours per genetic counsellor per case, and 7.5 hours per clinical geneticist per case.[7] This is not captured currently through ABF or non-admitted patients because the focus is on the time spent directly with patients.
- The cost of genetic counsellor time is not readily accessible as there is no specific 40 series allocation for genetic counsellors. Genetic counsellors are typically listed with Allied health not otherwise stated (NOS). Their level of qualification and accreditation are quite different to most allied health specialities.

If the IHPA were to undertake site visits in a selection of jurisdictions, as had been planned in 2020 through the Australian Non admitted Care Costing study, this would allow for better assessment of the data needed to estimate the costs of genetic services. Several genetic services have indicated they have been actively pursuing better collection of data with respect to activity and testing costs and would be happy to be involved in an updated pricing study to assist in determining the true cost of genetic services and testing.

Genetic services are costly to deliver. Although some aspects such as diagnostic testing may have reduced costs over time, other costs remain static, such as those relating to the time taken to undergo assessments and the cost of those assessments. The lack of appropriately billable activity for genetics means that practitioners ae not encouraged to provide these complex services. It can mean some patients are not adequately assessed.

Lack of pricing standards is another matter of concern. As a result of this issue, states do not invest in expanding these services because they are costly and generate less revenue. In turn, this makes it difficult to attract providers such as adult medicine physicians into this area of practice. In Australia, genetic counsellors/associates do not yet attract their own activity-based funding through mechanisms such as MBS.

[7] Nisselle, A. MacKenzie, F. et al 2018 Professional Status survey of genetic counsellors and clinical geneticists

- ***Ensuring sufficient accounting for all hospital episodes of care for older patients with cognitive impairment and Behavioural and Psychological Symptoms of Dementia***

We suggest that this review should also consider cases where appropriate provision has not been made for higher costs for patients with special needs in hospitals.

This is particularly pertinent to the significant and growing cohort of patients with cognitive impairment and non-cognitive behavioural and psychological symptoms of dementia (BPSD). Care of such patients requires significant resources (such as 24-hour special nursing and security services) and longer stays to stabilise these disruptive behaviours and render patients suitable for discharge to community carers or residential care. The cost of this care is not adequately captured within existing DRG classifications, despite the ability to code for some degree of medical complexity.

4. Future funding models

We welcome the IHPA's recognition that the existing ABF system could benefit from the incorporation of alternate funding models that have the potential to create better incentives for improved continuity of care and support use of evidence-based care pathways. The RACP supports such a move towards value-based care, along with a focus on outcomes over volume of services. It is also imperative that funding models factor in the need for sustained clinical leadership and that more integrated approaches are embedded.

Alternative funding models that are premised on more integrated approaches and operating principles will be important for both the care of older persons and of patients in any age group, including children, with more than one chronic condition. It is anticipated there will be ongoing and potentially increased demand associated with addressing the health needs of vulnerable and complex patients, along with catching up after cancelled or delayed medical appointments and admissions. For people in need of more intensive attention and treatment and those facing a risk of exacerbations from delayed comprehensive care, alternative funding models could relieve some pressure on the system.

Aged care and non-admitted patients

In our 2020 submission we noted that the operation of home visiting services provided by a multidisciplinary team, which is of relevance to care of elderly patients but may also apply to others, is currently not possible under Tier 2 Non-admitted services. We propose that in its investigation of innovative models of care the IHPA consider the funding of such services on a pilot basis and use this as an opportunity to examine the case for broader funding of such models which would occupy a space between admitted care and Tier 2 non admitted care services.

This is consistent with the Recommendation 58 of the Royal Commission into Aged Care Quality and Safety on "access to specialists and other health practitioners through Multidisciplinary Outreach Services" which is accepted in principle by the Australian Government.

Clinical engagement

The RACP urges that consultant physicians be represented among the clinical experts advising on the design of new classification and pricing systems, ensuring that proposed groupings for bundled payments and capitation models are clinically meaningful.

Funding model for complex conditions

The RACP recommends the IHPA consider the model of care described in the RACP Model of Chronic Care Management (MCCM) This model and its governance structure bridge primary and secondary care inclusive of Primary Health Networks and Local Health Networks. An advantage of the model is that it also enables virtual care. An essential consideration for alternative funding models concerns assigning the fund holder, which impacts a funding model's long-term success.

The MCCM model has been developed for patients with chronic complex conditions assessed as requiring 'intermediate' level of care, which links in with the drive to reduce unnecessary and potentially preventable hospitalisation. The target population are individuals who have cardiovascular related multi-morbidities and:

> (a) are at high risk of one or more hospital presentation or admission in the next twelve months; or
> (b) have already had one or more unnecessary or avoidable hospital presentations or admissions in the past twelve months; or
> (c) are receiving care in the community under GP care who may benefit from significant additional support or expertise. For such patients there may be a role for other medical practitioners in providing consulting advice to GPs (e.g., consultant physicians in particular diseases such as diabetes) or allied health professionals to contribute to more comprehensive care (e.g., dieticians, psychologists, exercise physiologist).

The model is based on a capitation financing method for team-based care that would include salaried hospital physicians being able to provide services in an ambulatory setting. This is a pooled funding approach, i.e., funded by pooling funding from Commonwealth and State governments into funds at the local hospital network area, with one possible source of funds suggested as being a modest share of current ABF of public hospitals contributed by both tiers of government. We have also proposed inclusion of a shared saving incentive mechanism recognising the potential for reduced ABF funded hospital activity. The model has provision for use of MBS billing items for less frequently needed services.

Under this proposal, the core healthcare team would comprise a care coordinator, GP and consultant physician but with scope to include other healthcare practitioners (e.g., allied health, specialist nurses) as appropriate. Members of the core team can come from the public hospital sector in which case their employer would collect a per patient payment in lieu of their time or, alternatively, they would collect the payments themselves if they are private practitioners in the community (we note that specialist physicians typically can be either or both).

Scale and sustaining innovations

The IHPA should also consider the limitations of scale when it comes to innovative models. A block funded approach could be made available for the start-up funding of small-scale models. However, it is important that the means of sustaining services is determined, either through further block funding for small services, or ABF for larger services.

Clinical leadership

Clinical leadership is essential to the success of future innovative funding models. This activity must be factored into the models which must clearly recognise this area of responsibility.

5. Pricing and funding for quality and safety

Pricing and funding approaches to be explored by the IHPA for reducing avoidable and preventable hospitalisations:

- Incentivising greater investment in non-admitted services, such as ambulatory based rehabilitation, hospital-in-the home and other outpatient services, especially for regional and smaller hospitals. These are important ways of providing high quality care to patients outside of a hospital environment (often more convenient to patients and carers) and of facilitating access to MBS-billed consultant physicians. Such services do not require capital expenditure, nor subsequent depreciation costs.

- Preventative care and secondary prevention. There is minimal funding for preventative care, such as secondary prevention that might be needed after a fall or a stroke, to avoid unnecessary second admission, morbidity and mortality. Secondary prevention should be funded explicitly so that falls prevention clinics and associated multidisciplinary services receive necessary resourcing and can contribute to reducing unnecessary admissions and mortality. Secondary preventative care often involves rehabilitation services, and it would be beneficial to enable community rehabilitation physicians to contribute to secondary preventive care services to reduce readmissions.

- Hospital-in-the-home is currently priced under the admitted acute care pricing model. In view of ongoing pressures on hospitals, developing an optimised funding model for this service will be of strategic importance in reducing admissions, including its potential to offset demand for acute beds in regional and rural areas.

- Potentially Preventable Hospitalisations (PPH) penalty. The IHPA could consider a penalty to disincentivise cost shifting between the LHN sector and the PHN sector where hospitalisations are concerned. This is premised on the primary sector being resourced to sufficiently provide appropriate health care services for its population, including provision for models of health care that can involve consultant physicians. One suggestion is to impose a penalty on LHNs calculated for any PPH over and above the age-standardised rate of 3,000 per 100,000 residents, when care could have been provided within the community through primary health care, were it appropriately resourced.

- Evaluation measures should include tracking funding structures that incentivise positive patient experience and outcomes in addition to solely incentivising activity.

6. Other comments

Of relevance to the IHPA's work is the urgent need and funding for more local research. The Pricing Framework only refers to research briefly under section on *Teaching and training*; this omission needs to be remedied in future work by the Authority.